STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009310	A. BUILDING _____ B. WING _____	C 09/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE MANOR	920 N SEMINARY AVE P O BOX 520 WOODSTOCK, IL 60098

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S9999	Final Observations Statement of Licensure Violations 330.1110a) 330.4220f) Section 330.1110 Medical Care Policies a) The facility shall have a written program of medical services approved in writing by the advisory physician that reflects the philosophy of care provided, the policies relating to this and the procedures for implementation of the services. The program shall include the entire complex of services provided by the facility and the arrangements to effect transfer to other facilities as promptly as needed. The written program of medical services shall be followed in the operation of the facility. Section 330.4220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) These regulations were not met as evidenced by: Based on interview and record review the facility failed to follow a physician's orders by not ensuring laboratory testing for determining blood clotting time was performed and failed to administer anti-coagulation medication for a resident with a history of clotting disorders. This applies 1 of 3 residents (R1) reviewed for	S9999	Attachment A Statement of Licensure Violations	

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medications in the sample of 3.
The findings include:
R1's Medication Records dated 5/2016 to 8/2016 show diagnoses including Alzheimer's Disease, heart disease, chronic obstructive pulmonary disease, cerebrovascular disease (blockage of blood flow to the brain), and cognitive communication deficient. R1's physical examination report dated August 27, 2016 shows a past medical history of PE's (pulmonary embolism-blood clot in the lungs), PFO (patent foramen ovale-hole in the heart), and TIA (transient ischemic attack-short period of blood flow blockage to the brain). R1's physical examination report also notes: she (R1) had been off her (Coumadin-anticoagulation /blood thinner medication) accidentally.
On August 31, 2016 at 9:00 AM, E1 (Administrator) stated R1 was recently admitted to the local hospital and it was discovered she had not been receiving her Coumadin while at the facility. E1 stated R1 had been moved from one unit in the facility to another and "that is where the medication got stopped". E1 stated, "I think it was a mix up between nurses on the different shifts. The medication order got messed up between units and I'm not sure if (the unit R1 was transferred to) ever received an order to start again."
On August 31, 2016 at 10:10 AM, E2 (Director of Nurses) stated a medication error was discovered while R1 was in the local hospital. E2 said R1's Coumadin was stopped in May 2016. E2 said there were many errors leading up the medication omission and it was "a system failure with the Coumadin situation". E2 said it was bad communication between the day and evening nurses (E4 and E5). E2 stated R1's physician changed the Coumadin dosage on May 10, 2016 and ordered a PT/INR test (blood test to

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determine blood clotting time and bleeding disorders) to be performed in one week (May 18, 2016). E2 stated the Coumadin dosage was to be increased to 10 milligrams for one week, followed by the blood test to determine follow up dosing. E2 said the blood test was never ordered nor performed and therefore the restart of the Coumadin never happened. E2 said the resident and the unit nurse (E5) were "newer to the unit and neither realized a (routine) medication was missing". E2 said a lab requisition ticket should have been completed on the day the physician placed the order. E2 stated the nurse receiving the lab order didn't know she had to hand write a requisition ticket and the labs were never ordered. E2 said the laboratory order was not communicated between nurses. E2 said the Coumadin was never restarted after May 18, 2016.

On August 31, 2016 at 11:50 AM, E4 (Registered Nurse-days) stated medications are not given if there is not an order from the doctor. The medication record shows which medications to give a resident. This surveyor and E4 reviewed the May 2016 medication record. E4 stated the record shows Coumadin was not administered beyond May 18, 2016. E4 said laboratory testing is scheduled by hand writing a paper request which is kept at nurse station one until the lab results are obtained. E4 and this surveyor reviewed R1's physician orders for May 2016 and noted an order for PT/INR to be done on May 18, 2016 but did not see any lab test results for that date.

On August 31, 2016 at 1:45 PM, E5 (Registered Nurse-evening) stated she did not remember what happened in May 2016 regarding R1's Coumadin dosage changes. E5 said, "I look at the chart (medication record) to see what was ordered and when to give it. If a medication is not

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there, I just don't give it." E5 said when a physician orders laboratory testing for a resident, a green lab order slip is filled out and kept in a file until the draw (test) date. The nurse must also physically call the laboratory to schedule the test and then they (lab staff) come to the facility to do the test.

On August 31, 2016 at 2:10 PM, E6 (Nurse Supervisor) stated she had no idea why R1's Coumadin was not re-started in May 2016. E6 said all the medication (dosage cards) had been removed from the medication cart "as if the med had been discontinued". E6 said when a nurse receives a physician order for a lab test, that nurse is responsible for putting the order into the computer and scheduling the test date with the laboratory staff.

On August 31, 2016 at 3:45 PM, E2 said there is no way of knowing if the doctor would have continued R1 on the Coumadin without the PT/INR blood test.

On August 31, 2016 at 5:10 PM, E3 (Medical Director/R1's physician) stated R1's Coumadin was necessary due to a patent foramen ovale (hole in the heart). E3 said R1 has the potential for small blood clots to travel out of the heart then to the brain, but in this case, the blood clot went to the lungs (pulmonary embolism). E3 said she was unaware R1 had not received the Coumadin since May 2016. E3 said R1 should have been receiving the medication to prevent blood clot formation. E3 said R1 normally receives blood tests in collaboration with her anti-coagulation medication. E3 said without the red flag (lab result) to alert her, she was unable to determine further medication dosage needs. E3 stated R1 was sent to the local hospital on August 28, 2016 due to a pulmonary embolism. E3 stated, "Yes, there is the possibility if (R1) had been on the medication, no pulmonary embolism would have

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happened."
R1's Medication Administration Records (MARs) show Coumadin was last administered May 18, 2016. R1's MARs dated June 2016 and July 2016 show no Coumadin administered. R1's August 2016 MAR shows Coumadin administration did not resume until August 27, 2016.
R1's Physician Orders dated May 11, 2016 shows an order for Coumadin 10 mg (milligram) tab (tablet) PO (by mouth) (5/11-5/12) and Coumadin 5 mg PO daily (5/13-5/18). There is no addition order for Coumadin after May 18, 2016 until August 27, 2016.
R1's Physician Orders shows an order received May 11, 2016 for : start date 5/13/16 Coumadin 5 mg (milligram) PO (by mouth) for 5/13-5/18 and recheck PT/INR. R1's Physician Orders also show an order received May 11, 2016 for : start date 5/18/16 PT/INR-; a.fib (atrial fibrillation) recheck in a week.
R1's laboratory test record shows PT/INR test results for April 18, April 25, May 10, and August 27, 2016. There are no PT/INR test results for May 18, 2016.
The facility was unable to provide a policy relating to physician orders or laboratory testing. The facility did provide an undated Anticoagulant Management Policy which stated: Protocol for (Coumadin): 4. Circle the date of the blood draw on the MAR and mark it with "PT/INR". 7. A lab requisition for the PT/INR draw will be filled out and lab will be notified of the draw date .....
The facility's Administering Oral Medications Policy dated November 2009 states: Review the resident's care plan to assess for any special needs of the resident. Be familiar with the resident's medical diagnosis and reason for administering the drug, as well as contraindications, usual dosages, side effects, and intended outcome of the drug.

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